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8 **BEFORE THE**
BOARD OF REGISTERED NURSING
9 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

10 In the Matter of the Accusation Against:

Case No. **2010-504**

11 **PATRICIA EILLEN VILLA, AKA**
12 **PATRICIA EILLEN DUNHAM**
13 **18621 Saticoy St., Apt. 104**
Reseda, CA 91335
14 **Registered Nurse License No. 221722**

ACCUSATION

15 Respondent.

16 Complainant alleges:

17 **PARTIES**

18 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
19 official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board),
20 Department of Consumer Affairs.

21 2. On or about February 29, 1972, the Board issued Registered Nurse License Number
22 221722 to Patricia Eileen Villa, aka Patricia Eileen Dunham (Respondent). The Registered
23 Nurse License was in full force and effect at all times relevant to the charges brought herein and
24 will expire on December 31, 2011, unless renewed.

25 **JURISDICTION**

26 3. This Accusation is brought before the Board under the authority of the following
27 laws. All section references are to the Business and Professions Code (Code) unless otherwise
28 indicated.

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5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

“(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.”

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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PATIENT L.G.

9. On or about November 27, 2006, at about 2255 hours, Patient L.G. was admitted to Aurora Las Encinas Hospital (Facility) in Pasadena, California for treatment of substance abuse and major depression. Patient L.G. reported to Facility staff that he had relapsed on alcohol and was abusing Oxycodone¹ for past three (3) years. The Facility's physician, Dr. Joseph Haraszti (Dr. Haraszti), prescribed the Facility's "CNS Narcotic Detox Protocol" and "Alcohol Detox Protocol", which included Librium² 25mg as needed, and Subutex³ 2mg three times daily. Orders were in place for the patient to be checked every fifteen minutes. The nursing assessment upon admission showed that Patient L.G. experienced suicidal ideation with depression, decreased motor activity, anxiety and irritability. At 0020 hours on November 28, 2006, Dr. Haraszti ordered a urine sample for drug screening.

10. On or about November 28, 2006, Dr. Haraszti noted that Subutex 6mg/day for this patient was "obviously not an adequate dose for him given his high level of opiate abuse," and ordered an increase of dosage of Subutex and an immediate dose of Librium 50mg for alcohol withdrawal symptoms. Nursing notes do not include a physical assessment addressing alcohol withdrawal, other than routine vital signs which were within normal limits.

11. On or about November 29, 2006, nursing notes at about 1700 hours indicate Patient L.G. was found "drowsy and sedated" and unresponsive to painful stimuli. Dr. Peter Ma, the Facility's Medical Service Director for Internal Medicine, charted that Patient L.G.'s respirations were "somewhat slowed", and noted "R/O post-ictal, secondary to alcohol⁴" L.G. was transported to San Gabriel Valley Medical Center Emergency Department for treatment. While at San

¹ OxyContin, a brand name formation of Oxycodone Hydrochloride, is an opioid agonist with an abuse liability similar to morphine. OxyContin is for use in opioid tolerant patients only. It is used to treat severe, acute pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1), and a dangerous drug pursuant to Business and Professions Code section 4022.

² Librium, used for anxiety resulting from symptoms of alcohol withdrawal, is a long-acting chlordiazepoxide with active metabolites lasting up to 200 hours.

³ Subutex, a buprenorphine, is a long-acting (24 -72 hours) partial narcotic opiate agonist-antagonist commonly prescribed for pain, but is also used to counteract or negate other opiates a patient may have ingested.

⁴ Meaning that Dr. Ma suspected the patient might have suffered a seizure due to alcohol withdrawal.

1 Gabriel Valley Medical Center, Patient L.G. was given Narcan⁵ and Flumazenil⁶. He tested
2 negative for opioids and all other drugs of abuse. The only drugs Patient L.G. tested positive for
3 were benzodiazepines, which were administered at the Facility. Dr. Haraszti documented that
4 L.G. might have been given illicit drugs by a girlfriend, and ordered the patient's room to be
5 searched.

6 12. At about 0300 hours on November 30, 2006, Patient L.G. was discharged from San
7 Gabriel Valley Medical Center and returned to the Facility. Upon return to the Facility, Dr.
8 Haraszti changed L.G.'s medications which included decreasing Subutex to 1mg, substituting
9 Librium with Serax among others, and documented that: "Since he was quite somnolent as a
10 result of Subutex, his Librium dosage may have been inadvertently reduced by the staff. . . It is
11 quite possible the patient may have exaggerated his opiates' usage prior to admission." In
12 response to L.G.'s inquiry to the cause of his hospitalization, nursing staff reported that he
13 experienced toxicity from a "combination of Librium and Suboxone." Dr. Haraszti ordered
14 nursing staff to take Patient L.G. vital signs every four hours, to monitor his vital signs "very
15 closely" and to perform 15-minute checks.

16 13. On or about December 1, 2006, nursing notes from the previous night shift do not
17 include vital signs, only the statement that the patient "slept through the night. Monitored every
18 15 minutes." At about 0930 hours, a clinical therapist discovered the patient in his room with the
19 door closed, unresponsive and "face and upper body were purple/cool to the touch."
20 Resuscitation efforts were initiated but failed. Patient L.G. expired. The coroner noted that
21 "rigor mortis was at stage IV throughout the body."

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27 ⁵ An antagonist for Subutex.

28 ⁶ An antagonist for Librium.

1 **CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct – Gross Negligence)**

3 14. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)
4 on the grounds of unprofessional conduct as defined under California Code of Regulations, title
5 16, section 1442, in that while employed as a registered nurse at the Facility providing care to
6 Patient L.G., Respondent committed gross negligence as follows:

- 7 a. Respondent was on duty as a charge nurse from 1500 to 2330 hours on November 30,
8 2006.
- 9 b. Respondent failed to thoroughly assess Patient L.G. consistent with standard nursing
10 practice for a patient who was being assessed for substance abuse withdrawal, who was
11 suspected of taking illicit substances, who just received emergent treatment for alcohol-
12 induced seizure, who received recent medication changes and who was at risk for acute
13 alcohol withdrawal. These failures include, but not limited to, the lack of monitoring of
14 the suspected illicit drug intake which resulted in a room search conducted the previous
15 evening, the absence of taking Patient L.G.'s vital signs, and the lack of assessment of
16 the level of pain and discomfort experienced by Patient L.G. Complainant refers to and
17 incorporates all the facts and allegations contained in paragraphs 9 - 13, as though set
18 forth fully.

19 **PRAYER**

20 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
21 and that following the hearing, the Board of Registered Nursing issue a decision:

22 1. Revoking or suspending Registered Nurse License Number 221722, issued to Patricia
23 Eilleen Villa, aka Patricia Eilleen Dunham;

24 2. Ordering Patricia Eilleen Villa, aka Patricia Eilleen Dunham to pay the Board of
25 Registered Nursing the reasonable costs of the investigation and enforcement of this case,
26 pursuant to Business and Professions Code section 125.3;

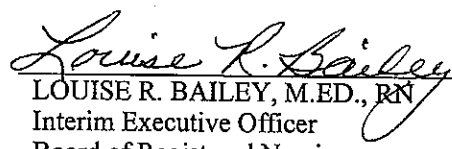
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3. Taking such other and further action as deemed necessary and proper.

DATED: 4/14/10


LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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